Initial Approval: January 10, 2018

CRITERIA FOR PRIOR AUTHORIZATION

Elaprase® (idursulfase)

PROVIDER GROUP Professional

MANUAL GUIDELINES The following drug requires prior authorization:
idursulfase (Elaprase®)

CRITERIA FOR APPROVAL (must meet all of the following):

- Patient must have a diagnosis of Hunter syndrome (mucopolysaccharidosis type II)
- The patient's baseline 6-minute walk test results must be provided
- Patient must be 5 years of age or older
- Dose must not exceed 0.5 mg/kg given as an IV infusion once a week

CRITERIA FOR RENEWAL (must meet all of the following):

- The patient's current 6-minute walk test results must be provided and show an increase in the distance walked
- Dose must not exceed 0.5 mg/kg given as an IV infusion once a week

LENGTH OF APPROVAL: 12 months

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DRUG UTILIZATION REVIEW COMMITTEE CHAIR

_____
PHARMACY PROGRAM MANAGER
DIVISION OF HEALTH CARE FINANCE
KANSAS DEPARTMENT OF HEALTH AND ENVIRONMENT

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DATE

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DATE